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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LORRIE LELA HARVEY-CRAIG** **AKA LORRIE CRAIG** **AKA LORRIE HARVEY NATIVO** **AKA LORRIE LELA HARVEY** Respondent.	Case No. 2009-248 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about April 15, 2009, Complainant Ruth Ann Terry, M.P.H., R.N., in her official capacity as the Executive Officer of the Board of Registered Nursing, filed Accusation No. 2009-248 against Lorrie Lela Harvey-Craig aka Lorrie Craig aka Lorrie Harvey Nativo aka Lorrie Lela Harvey (Respondent) before the Board of Registered Nursing.

2. On or about May 17, 1999, the Board of Registered Nursing issued Registered Nurse License No. 555101 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2010, unless renewed.

3. On or about April 24, 2009, Corinia Talaro, an employee of the Department of Justice, served by Certified and First Class Mail a copy of the Accusation No. 2009-248,

Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board of Registered Nursing, which was and is: 490 Lark Road, Wrightwood, CA 92397 and P.O. Box 2860 , Wrightwood, CA 92397. A copy of the Accusation is attached as exhibit A, and is incorporated herein by reference.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. On or about May 1, 2009, the aforementioned documents were returned by the U.S. Postal Service marked "Refused ."

6. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2009-248.

7. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

8. Pursuant to its authority under Government Code section 11520, the Board of Registered Nursing finds Respondent is in default. The Board of Registered Nursing will take action without further hearing and, based on the evidence on file herein, finds that the allegations in Accusation No. 2009-248 are true.

9. The total cost for investigation and enforcement in connection with the Accusation are $8,827.00 as of July 8, 2009.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Lorrie Lela Harvey-Craig aka Lorrie Craig aka Lorrie Harvey Nativo aka Lorrie Lela Harvey has subjected her Registered Nurse License No. 555101 to discipline.

2. A copy of the Accusation is attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation:

a. Respondent is subject to disciplinary action under section 2761, subdivision (a), as defined in section 2762, subdivision (e), for violating Health and Safety Code section 11173, subdivision and (b), in that between approximately July 31, 2006 and approximately March 22, 2007, while on duty as a registered nurse at San Gorgonio Memorial Hospital (SGMH), in Banning, CA, and thereafter at Parkview Community Hospital (PCH), in Riverside, CA, Respondent falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances and dangerous drugs on numerous occassions, involving numerous patients.

b. Respondent is subject to further disciplinary action under section 2761, subdivision (a), as defined in section 2762, subdivision (a), for violating Health and Safety Code section 11173, subdivision (a), in that while working as a registered nurse at Parkview Community Hospital and San Gorgonio Community Hospital, Respondent obtained controlled substances by fraud or deceit.

c. Respondent is subject to further disciplinary action under section 2761, subdivision (a), as defined in section 2762, subdivision (b), in that Respondent used controlled substances in a manner that was dangerous to herself and others. Specifically, on or about April 11, 2006, while attending Palm Springs Serenity Retreat, in Palm Springs, California, a rehabilitation center, Respondent relapsed after having completed a 30 day residential treatment program. Respondent was using Lunesta without a prescription and methamphetamine.

d. Respondent is subject to further disciplinary action under section 2761, subdivision (a), for engaging in unprofessional conduct, by failing to cooperate with the Board's investigations. In September 2007, an investigator for the Board attempted to contact Respondent by mail; however, no response was received.

ORDER

IT IS SO ORDERED that Registered Nurse License No. 555101, heretofore issued to Respondent Lorrie Lela Harvey-Craig aka Lorrie Craig aka Lorrie Harvey Nativo aka Lorrie Lela Harvey, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on December 25, 2009.

It is so ORDERED November 25, 2009

FOR THE BOARD OF REGISTERED NURSING

60434082.doc
DOJ docket number LA2008600409

Attachment: Exhibit A: Accusation No.2009-248

Exhibit A

Accusation No. 2009-248

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LORRIE LELA HARVEY-CRAIG aka LORRIE CRAIG AKA LORRIE aka HARVEY NATIVO aka LORRIE LELA HARVEY 490 Lark Road Wrightwood, CA 92397 and P.O. Box 2860 Wrightwood, CA 92397 Registered Nursing License No. 555101 Respondent.	Case No. 2009-248 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about May 17, 1999, the Board of Registered Nursing (Board) issued Registered Nursing License No. 555101 to Respondent Lorrie Lela Harvey-Craig, also known as Lorrie Craig, Lorrie Harvey Nativo, and Lorrie Lela Harvey (Respondent). The

Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2010, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

STATUTORY PROVISIONS

4. Code section 2750 provides, in relevant part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct . . . ."

6. Section 2762 states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use

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impairs his or her ability to conduct with safety to the public the practice authorized by his or her license."

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

7. Section 2764 provides, in relevant part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

8. Health and Safety Code section 11173 states:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation , or subterfuge; or (2) by the concealment of a material fact.

"(b) No person shall make a false statement in any prescription, order, report, or record, required by this division."

COST RECOVERY

9. Section 125.3 of the Code provides, in relevant part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

10. **CONTROLLED SUBSTANCES**

a. "Dilaudid," is the trade name for Hydromorphone. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(k), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

b. "Demerol," is a brand of meperidine hydrochloride, a derivative of pethidine. It is a Schedule II controlled substance as designated by Health and Safety Code

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section 11055, subdivision (c)(17) and is categorized as a "dangerous drug" pursuant to Business and Professions Code section 4022.

c. "Lunesta," a the trade name for eszopiclone an S-isomer of zoplicone. It is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d) and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

d. "Methamphetamine," is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (d)(2), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

e. "Morphine/Morphine Sulfate," is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(m), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

f. "Norco's the brand name for the combination narcotic, Hydrocodone and Acetaminophen. Hydrocodone is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(j), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022. Acetaminophen is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(2), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022

g. "Percocet," is the brand name for Oxycodone. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(n), and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022.

11. **DEFINITIONS**

a. "Controlled Substance Administration Record" is a manual "sign out" system for narcotics rather than an automated dispensing system. Each nurse signs out the drug that is ordered by listing the patient's name and their room number. A current total of the number of doses for each particular drug is kept manually.

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b. "Pyxis" is a computerized automated medication system with operates similarly to an automated teller machine at a bank. Medications can be withdrawn from the Pyris machines only by an authorized staff person using his or her own personalized access code. The Pyris machine makes a record of the medication and dose, date and time it was withdrawn, the user identification, and the patient for whom it was withdrawn.

FIRST CAUSE FOR DISCIPLINE

(Falsified Hospital Records)

12. Respondent is subject to disciplinary action under section 2761, subdivision (a), as defined in section 2762, subdivision (e), for violating Health and Safety Code section 11173, subdivision and (b), in that while on duty as a registered nurse at Parkview Community Hospital (PCH), in Riverside, CA and San Gorgonio Memorial Hospital (SGMH), in Banning, CA, Respondent falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances and dangerous drugs in the following respects:

Parkview Community Hospital (PCH)

Patient 5750

a. On or about March 1, 2007, Respondent removed one dose of I.V. Morphine 5mg. at 1002 hours and one dose of I.V. Morphine 5mg. at 1248 hours from the Pyxis for patient no. 5750. Respondent charted the administration of only one dose of I.V. Morphine 5mg. in the patient's Medication Administration Record (MAR).; Resulting in a discrepancy of 5mg of Morphine. The physician orders were for I.V. Morphine 5mg. every 2 hours as needed for severe pain. This order was changed at 1425 hours to Demerol 75mg. every 2 hours.

b. On or about March 1, 2007, at 1502 hours, Respondent removed Demerol 75mg. from the Pyxis for patient no. 5750. Respondent documented the administration of Demerol 75mg. in the patient's flow sheet at 1700 hours, two hours after she removed the drug from the Pyxis. Respondent failed to record wastage or otherwise account for Demerol 75mg., which resulted in a discrepancy of 75mg. of Demerol.

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Patient 5888

c. On or about March 1, 2007, at 0808 hours, Respondent removed Dilaudid 2mg. from the Pyxis for patient no. 5888. Respondent failed to chart the administration of Dilaudud 2mg. in the patient's MAR, and failed to document the administration of Dilaudid 2mg. in the patient's flow sheet. Respondent failed to record wastage or otherwise account for Dilaudid 2mg. The physician orders were for Dilaudid 2mg. every 4 hours as needed for severe pain.

d. On or about March 1, 2007, at 1226 hours, Respondent removed Dilaudid 2mg. from the Pyxis for patient no. 5888. Respondent failed to chart the administration of Dilaudud 2mg. in the patient's MAR, and failed to document the administration of Dilaudid 2mg. in the patient's flow sheet. Respondent failed to record wastage or otherwise account for Dilaudid 2mg.

e. On or about March 1, 2007, at 1611 hours, Respondent removed Dilaudid 2mg. from the Pyxis for patient no. 5888. Respondent failed to chart the administration of Dilaudud 2mg. in the patient's MAR, and failed to document the administration of Dilaudid 2mg. in the patient's flow sheet. Respondent failed to record wastage or otherwise account for Dilaudid 2mg. The total resultant discrepancy for this patient was 6mg of Dilaudid.

Patient 7058

f. On or about March 16, 2007, at 0756 hours, Respondent removed one dose of I.M. Morphine 10mg. and one dose of I.M. Morphine at 1303 hours from the Pyxis for patient no. 7058. Respondent charted the administration of only one dose of I.M. Morphine 10mg. in the patient's MAR, and documented the administration of only one dose of I.M. Morphine 10mg. in the patient's flow sheet. Respondent failed to record wastage or otherwise account for Morphine 10mg. The total discrepancy for this patient was 10 mg. of Morphine. The physician orders were for I.M. Morphine 10mg. every 4 hours as needed for severe pain.

Patient 7108

g. On or about March 22, 2007, at 0835 hours, Respondent removed Morphine 2mg. from the Pyxis for patient no. 7108. Respondent failed to chart the

administration of Morphine 2mg in the patient's MAR. Respondent failed to record wastage or otherwise account for Morphine 2mg. The physician orders were for Norco 2 tablets every 4 hours as needed, and Morphine 2mg. every 4 hours as needed for breakthrough pain.

h. On or about March 22, 2007, at 1034 hours, Respondent removed Morphine 2mg. and two Norco tablets from the Pyxis for patient no. 7108. Respondent failed to chart the administration of Morphine 2mg. and two Norco tablets in the patient's MAR. Respondent failed to record wastage or otherwise account for Morphine 2mg. and two Norco tablets.

i. On or about March 22, 2007, at 1313 hours, Respondent removed Morphine 2mg. from the Pyxis for patient no. 7108. Respondent failed to chart the administration of Morphine 2mg. in the patient's MAR. Respondent failed to record wastage or otherwise account for Morphine 2mg.

j. On or about March 22, 2007, at 1526 hours, Respondent removed two Norco tablets from the Pyxis for patient no. 7108. Respondent failed to chart the administration of two Norco tablets in the patient's MAR. Respondent failed to record wastage or otherwise account for two Norco tablets. The total discrepancy for this patient was 6mg. Morphine and four (4) Hydrocodone tablets.

Patient 7113

m. On or about March 22, 2007, at 1001 hours, Respondent removed Dilaudid 1mg. from the Pyxis for patient no. 7113. Respondent failed to chart the administration of Dilaudid 1mg. in the patient's MAR, and failed to document the administration of Dilaudid 1mg. in the patient's flow sheet. The physician orders were for Demerol 75mg. every 3 hours as needed for pain, and Dilaudid 1mg. The total discrepancy for this patient was 1mg. Dilaudid.

Patient 7401

n. On or about March 1, 2007, at 0855 hours, Respondent removed Dilaudid 2mg. from the Pyxis for patient no. 7401. Respondent failed to chart the administration of Dilaudid 2mg. in the patient's MAR, and failed to document the administration of

Dilaudid 2mg. in the patient's flow sheet. Respondent failed to record wastage or otherwise account for Dilaudid 2mg. The physician orders were for Dilaudid 2mg. every 3 hours as needed, and Morphine every 2 hours.

o. On or about March 1, 2007, at 1119 hours, Respondent removed Dilaudid 2mg. from the Pyxis for patient no. 7401. Respondent failed to chart the administration of Dilaudid 2mg. in the patient's MAR, and failed to document the administration of Dilaudid 2mg. in the patient's flow sheet. Respondent failed to record wastage or otherwise account for Dilaudid 2mg.

p. On or about March 1, 2007, at 1426 hours, Respondent removed Dilaudid 2mg. from the Pyxis for patient no. 7401. Respondent failed to chart the administration of Dilaudid 2mg. in the patient's MAR, and failed to document the administration of Dilaudid 2mg. in the patient's flow sheet. Respondent failed to record wastage or otherwise account for Dilaudid 2mg. The total discrepancy for this patient was 6mg. Dilaudid.

Patient 7974

q. On or about March 22, 2007, at 0834 hours, Respondent removed Dilaudid 1mg. from the Pyxis for patient no. 7974. Respondent failed to chart the administration of Dilaudid 1mg. in the patient's MAR, and failed to document the administration of Dilaudid 1mg. in the patient's flow sheet. The physician orders were for Dilaudid 0.5mg. to Dilaudid 1.5mg. depending on the level of pain.

r. On or about March 22, 2007, at 1308 hours, Respondent removed Dilaudid 1mg. from the Pyxis for patient no. 7974. Respondent failed to chart the administration of Dilaudid 1mg. in the patient's MAR, and failed to document the administration of Dilaudid 1mg. in the patient's flow sheet. The total discrepancy for this patient was 2mg of Dilaudid.

Patient 8883

s. On or about March 22, 2007, at 0832 hours, Respondent removed Dilaudid 1mg. from the Pyxis for patient no. 8883. Respondent failed to chart the administration of Dilaudid 1mg. in the patient's MAR, and failed to document the administration of

Dilaudid 1mg. in the patient's flow sheet. The physician orders were for Dilaudid 1mg. every 2 hours as needed for pain.

t. On or about March 22, 2007, at 1138 hours, Respondent removed Dilaudid 1mg. from the Pyxis for patient no. 8883. Respondent failed to chart the administration of Dilaudid 1mg. in the patient's MAR, and failed to document the administration of Dilaudid 1mg. in the patient's flow sheet.

u. On or about March 22, 2007, at 1315 hours, Respondent removed Dilaudid 1mg. from the Pyxis for patient no. 8883. Respondent failed to chart the administration of Dilaudid 1mg. in the patient's MAR, and failed to document the administration of Dilaudid 1mg. in the patient's flow sheet. The total discrepancy for this patient was 3mg. of Dilaudid.

Patient 9040

v. On or about March 11, 2007, at 1109 hours, Respondent removed one Percocet tablet and one Percocet tablet at 1607 hours from the Pyxis for patient no. 9040. Respondent charted the administration of only one Percocet tablet in the patient's MAR at 1600 hours. Respondent failed to record wastage or otherwise account for one Percocet tablet. The physician orders were for Demerol 75mg. every 3 hours as needed, and 1 Percocet tablet every 3 hours as needed for moderate pain.

w. On or about March 11, 2007, at 1159 hours, Respondent removed one dose of Demerol 75mg. and two additional doses of Demerol 75mg. at 1606 hours and against 1846 from the Pyxis for patient no. 9040. Respondent charted the administration of Demerol 75mg. in the patient's MAR at 1215 hours, 1606 hours, and 1830 hours.

x. On or about March 12, 2007, at 0805 hours, Respondent removed Demerol 75mg. and four additional doses of Demerol 75mg. at 1106 hours, 1331 hours, 1609 hours, and 1856 hours from the Pyxis for patient no. 9040. Respondent charted the administration of Demerol 75mg. in the patient's MAR at 0800 hours, 1300 hours, and "6 hours." Respondent failed to record wastage or otherwise account for Demerol 150mg.

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y. On or about March 12, 2007, Respondent removed three Percocet tablets from the Pyxis for patient no. 9040. Respondent charted the administration of only two Percocet tablets in the patient's MAR. Respondent failed to record wastage or otherwise account for one Percocet tablet. The total discrepancies for this patient was 150mg. of Demerol and 2 Percocet tablets.

Patient 9300

z. On or about March 12, 2007, at 0807 hours, Respondent removed one dose of Morphine 2mg. and five additional doses of Morphine 2mg. at 1107 hours, 1317 hours, 1546 hours, 1722 hours, and 1855 hours from the Pyxis for patient no. 9300. Respondent charted the administration of four Morphine 2mg. doses in the patient's MAR. Respondent failed to record wastage or otherwise account for Morphine 4mg. The total discrepancy for this patient was 4mg. of Morphine. The physician orders were for Morphine 2mg. every hour as needed for severe pain. The total discrepancy for this patient was 4mg. of Morphine.

Patient 9859

aa. On or about March 17, 2007, at 0907 hours, Respondent removed one dose of Morphine 4mg. and two additional doses of Morphine 4mg. at 1405 hours, and 1901 hours from the Pyxis for patient no. 9859. Respondent charted the administration of Morphine 4mg. in the patient's MAR at 0800 hours, an illegible time, and 1830 hours. The physician orders were for Morphine 2mg. every hour as needed for severe pain.

Patient 9906

bb. On or about March 16, 2007, at 0752 hours, Respondent removed one dose of Demerol 75mg. and three additional doses of Demerol 75mg. at 1035 hours, 1357 hours, and 1709, hours from the Pyxis for patient no. 9906. Respondent charted the administration of only two Demerol 75mg. doses in the patient's MAR, and documented the administration of all Demerol 75mg. doses in the patient's Pain Assessment portion of chart. Respondent failed to record wastage or otherwise account for Demerol 150mg. The physician orders were for Demerol 75mg. every 3 hours as needed for pain. The total discrepancy for this patient was 150mg. of Demerol.

San Gorgonio Memorial Hospital (SGMH)

Patient No. 682

cc. On or about August 3, 2006, Respondent documented that patient received 3 doses of I.V. Dilaudid at 0740 hours, 0940 hours, and 1400 hours for patient no. 682. Respondent signed out 4 doses of I.V. Dilaudid on the Controlled Substance Administration Record (CSAR). Respondent failed to record wastage or otherwise account for Dilaudid 2mg. The total discrepancy as to this patient was 2mg. of Dilaudid.

Patient No. 095

dd. On or about August 24, 2006, Respondent reported that she administered 3 doses of I.V. Morphine Sulfate 2mg. at 1030 hours, 1250 hours, and 1500 for patient no. 095 however Respondent failed to record wastage or otherwise account for Morphine Sulfate 2mg. The total discrepancy as to this patient was 2mg. Morphine.

Patient No. 878

ee. Respondent arrived to work at 0645 hours on August 24, 2006 and documented that at 0640 hours the patient was upset, so she started an I.V. to administer medication to patient no. 878. Patient no. 878 did not however have access to I.V. because the line had become nonfunctional during the night and was to be removed. Respondent charted that she administered I.V. Dilaudid at 0730 hours, 1118 hours, and 1340 hours. The patient was transferred to a psychiatric facility at 1420 hours. Respondent did not remove the nonfunctioning line and the patient was transferred with the line still in his arm. The physician orders from the night before indicated that the IV was to be left out.

Patient No. 311

ff. On or about August 1, 2006, Respondent signed out three doses of Dilaudid 2mg. on the CSAR, for patient no. 311. Respondent charted the administration of only two doses of Dilaudid 2mg in the patient's MAR. Respondent failed to record wastage or otherwise account for Dilaudid 2mg. The total discrepancy as to this patient was 2mg. Dilaudid.

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Patient No. 426

gg. On or about July 31, 2006, when Respondent was not scheduled to work, Respondent signed out Morphine Sulfate 4mg. from the CSAR, for patient no. 426 at 1000 hours. Respondent charted the administration of Morphine Sulfate 4mg in the patient's MAR at 0915 hours. The time that Respondent signed out and administered Morphine Sulfate 4mg are inconsistent. Additionally, Respondent charted that she administered a dose at 1000 hours in the patient's MAR, the previous day.

Patient No. 930

hh. On or about July 31, 2006, at 1030 hours, Respondent signed out Morphine Sulfate 4mg on the CSAR, for patient no. 930. Respondent failed to chart the administration of Morphine Sulfate 2mg in the patient's MAR. Respondent failed to record wastage or otherwise account for Morphine Sulfate 2mg. The physician orders were changed at about 1100 hours from Morphine Sulfate 4mg. to Dilaudid 2 mg.

ii. On or about July 31, 2006, at 1100 hours, Respondent signed out one dose of Dilaudid 2mg. and three additional doses of Dilaudid 2mg. at 1300 hours, 1530 hours, and 1730 hours on the CSAR, for patient no. 930. Respondent charted the administration of only three doses of Dilaudid 2mg in the patient's MAR. The 1530 hours dosage was not properly signed out on the CSAR. Respondent failed to record wastage or otherwise account for Dilaudid 2 mg.

jj. On or about August 3, 2006, at 0730 hours, Respondent signed out one dose of Dilaudid 2mg. and three additional doses of Dilaudid 2mg. at 0930 hours, 1210 hours, and 1500 hours on the CSAR, for patient no. 930. Respondent charted the administration of only three doses of Dilaudid 2mg in the patient's MAR. Additionally, Respondent signed out all four doses of the medication, under the wrong patient's name. Respondent failed to record wastage or otherwise account for Dilaudid 2mg. The total discrepancy as to this patient was 2mg. Morphine Sulfate and 4mg. Dilaudid.

Patient No. 127

kk. On or about August 12, 2006, at 2100 hours, Respondent administered one

dose of Morphine Sulfate 3mg. and one dose of Morphine Sulfate 3mg. at 2300 hours, as ordered prior to the change. Respondent signed out one dose of Dilaudid at 2340 hours and three additional doses of Dilaudid at 0110 hours, 0240 hours, and 0400 hours on the CSAR, for patient no. 930. Respondent charted the administration of Dilaudid in the patient's MAR at 2340 hours, 0100 hours, 0300 hours, and 0410 hours. Respondent failed to record wastage or otherwise account for Morphine Sulfate 1mg, when it was not properly wasted and signed off by a witness at 2100 hours. The time frames of when the medication was signed out and administered were inconsistent. Respondent signed out the 2300 hours dose of Morphine before she signed out the dose at 2100 hours. The analgesic orders for this patient were changed at 2330 hours from Morphine Sulfate 3mg. to Vicodin. Dilaudid was ordered every 2 hours as needed for breakthrough pain.

13. Respondent, on three (3) separate work shifts on August 4, 2006, August 9, 2006 and August 24, 2006, made numerous charting discrepancies on patient CSAR, including, but not limited to time sequence being out of range when signing out medications, entries being written illegibly, and/or entries being written over completely.

14. On or about August 24, 2006, Respondent was involved in medication error involving the following patients:

Patient A

a. Respondent received a call from the lab at 0712 hours, indicating patient A had a critical high value for sodium. Several hours later, Respondent erroneously told the physician that the patient's Potassium level was high. The physician wrote an order for Kayexalate to lower the Potassium. Respondent instructed the LVN to administer Kayexalate. Although only one-half of the liquid dose was given. Respondent failed to chart that any amount of Kayexalate was administered in the patient record or nursing notes. Respondent's misconduct resulted in an incident report.

Patient B

b. Respondent received a call from the lab at 0712 hours, indicating patient B had a critical high value for Potassium. The physician gave a telephone order for Kayexalate.

Respondent erroneously wrote August 23, 2006 at 1300 over another number and signed and dated the order at 1330 hours. The LVN attempted to administer Kayexalate to this patient at 1200 hours, but patient B refused the dose. The LVN charted this in the narrative notes. Respondent documented that she informed a different physician about the high Potassium value.

Patient C

c. This patient had a physician order written at 1340 hours that called for patient C to receive a 40 mEq dose of Potassium, prior to his discharge later that day. Respondent was the discharge nurse and charted that patient C went home at 1509 hours. However, Respondent failed to administer the ordered dose of Potassium.

SECOND CAUSE FOR DISCIPLINE

(Obtained Controlled Substances by Fraud or Deceit)

15. Respondent's license is subject to disciplinary action under section 2761, subdivision (a), as defined in section 2762, subdivision (a), for violating Health and Safety Code section 11173, subdivision (a), in that while working as a registered nurse at Parkview Community Hospital and San Gorgonio Community Hospital. Respondent obtained controlled substances. Complainant refers to, and by this reference incorporates the allegations in paragraphs 12 through 13, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Dangerous Use of Controlled Substances)

16. Respondent is subject to disciplinary action under section 2761, subdivision (a), as defined in section 2762, subdivision (b), in that Respondent used controlled substances in a manner that was dangerous to herself and others. On or about April 11, 2006, the Board received a complaint from the Clinical Director of Palm Springs Serenity Retreat, in Palm Springs, California , a rehabilitation center. The Clinical Director reported receiving a telephone call stating that Respondent had relapsed, after having completed a 30 day residential treatment program and was using such substances as methamphetamine and Lunesta without a prescription therefore.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Cooperate with the Board's Investigations)

17. Respondent is subject to disciplinary action under section 2761, subdivision (a), for engaging in unprofessional conduct, by failing to cooperate with the Board's investigations. In September 2007, an investigator for the Board attempted to contact Respondent by mail, however, no response was received.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License No. 555101, issued to Respondent.

2. Ordering Respondent to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3.

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/15/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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